Create and Quantify Value in Value-Based Care

June 2021

VBC takes the axiom "spend money to make money" one step further. It opens the possibility of spending money to make someone else money too.

The axiom that you need to spend money to make money wasn't conceived for value-based care (VBC). Still, it could have been — the advice is as relevant for healthcare as any business. But VBC takes the suggestion one step further. It opens the possibility of spending money to make someone else money too.

Such lucrative altruism is increasingly in demand. And providers can use it to differentiate themselves while efficiently managing and coordinating care. That's particularly the case since COVID-19 brought the urgency of VBC into even starker relief.

It seems counterintuitive that increased operational costs could lead to savings for healthcare providers and their payers. But healthcare isn't predicated on the simple provision of services; it's predicated on lives. And hospitals are now diversifying their reimbursement portfolio away from fee-for-service models toward new payer–provider partnerships in which incomes are contingent on outcomes.

These VBC partnerships focus on delivering quality while controlling costs. Often that requires an increase in certain costs to reduce other costs. For example, keeping patients in hospital beds for longer and then providing additional outpatient care increases short-term operational costs, but it also decreases readmission rates. Although individual cases vary, that leads to an overall reduction in total costs — clinical, administrative and operational — over time. Those savings then can be distributed as "shared savings" between the providers and the payers.

From a broad perspective, VBC already has produced results for payers, patients and providers. VBC models now account for 36 percent of healthcare payments in the United States and cover more than 227 million Americans across federal, state and commercial payers.[1] In 2018, Humana's Medicare Advantage plan had 20 percent lower medical costs than traditional Medicare, and their providers earned 10 cents more for every healthcare dollar spent.[2] Moreover, 77 percent of payers noticed an improvement in care quality for patients when implementing VBC in partnership with providers.[3]

To speed up the progression to VBC, changes also are happening on a more local level. Innovative organizations are now using VBC to accelerate positive clinical and financial outcomes for their stakeholders. At Orlando Health, we're applying targeted population health and VBC initiatives across our healthcare system. We regularly pilot, implement, test and refine new models to cut costs while improving clinical outcomes and patient experiences. Robust analytics allow us to test multiple initiatives and then quickly scale learnings across our network.

1. "2019 APM Measurement Infographic," HCPLAN, 2019.
2. "Humana Value-Based Care Report: Highlighting Physician Progress and Patient Outcomes," Humana, 2019.
3. "Finding the Value: The State of Value-Based Care in 2018," Change Healthcare, June 2018.

Health systems historically have not applied an analytical mindset to operational effectiveness.

In this paper, we explore how to create and quantify value in VBC across four areas:

- Looking for Value
- Identifying Value
- Demonstrating Value
- Managing Value

Looking for Value

Developing and operating an effective population health model to manage value-based payer arrangements requires significant investments in technology and analytics. Part of the challenge is that healthcare data is inherently complex and has nuances that vary from source to source. Effectively analyzing large sets of healthcare data remains a challenge.[4]

Health systems historically have not applied an analytical mindset to operational effectiveness. And implementing VBC still poses a challenge to most healthcare operators trying to boost efficiency, better coordinate services and improve margins across their networks.

As a business model, VBC can improve outcomes in several critical operating areas, including the individual hospital level:

- **Quality & Outcomes**, including improved mortality rates and fewer clinical complications
- **Utilization Efficiencies**, including reduced readmission rates and lengths of stay
- **Patient Experiences**, including improved patient satisfaction and engagement
- **Internal Cost Reductions**, including streamlined workflows and reductions in system waste
- **External Value Generation**, including lower cost of care for payers, employers and patients

Several of these areas directly affect hospital margins in the short and long term. They also are associated with possible incentives tied to payer reimbursements that affect revenue, such as Accountable Care Organization (ACO) shared savings rewards, pay for performance programs and federal hospital quality programs. So, an effective approach to VBC implementation may have multiple economic advantages, including:

- Improved operating costs to deliver care more efficiently by streamlining approaches and providing greater insights into costs
- Maximized payer reimbursements and qualification for bonuses via improved performance on key metrics tied to rate increases
- Avoidance or mitigation of costly penalty programs that sap funds through suboptimal operating performance indicators

4. "Are Electronic Health Records Useful Yet?" Yale Insights, February 5, 2020.

VBC efficiencies are payer agnostic. Learnings and improvements are generally transferable beyond just insured populations.

Identifying Value

Establishing profitability under current conditions requires enhanced data analytics to improve clinical outcomes and control internal and external costs.

A test-and-learn approach to data analysis is commonly used in industries from retail to telecommunications and is often tailored to individual organizations within each sector. In healthcare, the approach enables health systems and hospitals to quantify the causal impact of VBC by measuring results against a well-matched control. This enables providers to understand which patients or areas respond best and then identify how to maximize return on investment for each initiative, program or department.

The test-and-learn vision is similar to Continuous Quality Improvement (CQI), Plan-Do-Check-Act (PDCA) and Lean-Six Sigma (LSS). Significant benefit comes from quantifying the previously unknown value of programs to then target and tailor expansion across a health system or individual hospital. This adaptability also allows hospitals to react rapidly to changing environmental circumstances.

Moreover, a test-and-learn approach can have a halo effect on other unrelated initiatives. For example, consumer marketing can be improved through a better understanding of physician ratings, more sophisticated referral measurements and clinical campaign success evaluations. VBC efficiencies also are payer agnostic because learnings and improvements are generally transferable beyond just insured populations.

Demonstrating Value

At Orlando Health, we recently partnered with Mastercard to analyze success in several VBC programs across our integrated healthcare delivery system in Central Florida. Our partnership employed Mastercard's patented Test & Learn® solution and focused on three main areas:

- **Clinical Standardization** — evaluating our Right Care clinical order set for heart failure (HF) patients
- **Process Enhancements** — determining the effectiveness of a concierge scheduler model to improve the care coordination of HF patients after discharge
- **Patient Connectedness** — assessing our REACH (Readmission Advocates Collaborating in Healthcare) program, in which social workers address clinical and socioeconomic barriers to reduce readmission rates

Clinical Standardization

Our Right Care evaluation analyzed established treatment order sets for inpatients to see if those evidence-based models delivered better outcomes than a control group. After controlling for clinical and demographic variables within the patients, the test-and-learn analysis focused on clinical outcomes as measured by readmission rates, lengths of stay and cost of care. The collective Right Care order set includes more than a dozen protocols, such as assessing metabolic levels, taking vitals and performing echocardiograms.

The results:

Each Medicare patient benefitting from Right Care saw on average:

- A reduction of $4,800 in allowed spend over the 90-day, post-discharge period
- 1.3 fewer readmissions over the 90-day, post-discharge period

These improvements are estimated to represent an annual reduction of nearly 650 readmissions across the health system and significantly decrease overall cost to payers and patients.

Process Enhancements

We implemented our concierge scheduler model to ensure HF patients have a plan of action that includes a scheduled follow-up visit at the HF clinic within seven days of discharge.

The test-and-learn analysis showed:

- The model reduced 30-day readmissions by approximately 15 percent
- HF clinic follow-up visit rates more than doubled
- HF clinic no-show rates significantly decreased
- Patient experience scores markedly improved

We are now working to expand the model across other in-network hospitals and to other clinical conditions and medical specialties.

Patient Connectedness

Our REACH program is designed to provide follow-up support to patients with chronic and complex conditions who lack supportive resources and have a greater chance of readmission. The test-and-learn evaluation of REACH patients revealed statistically significant benefits for those in select diagnosis-related groups (DRGs). As a result of the study, the REACH team has reprioritized resources to focus on patients within DRGs shown to have experienced the greatest reductions in readmissions and the most improved outcomes. This analysis helped us realize clinical and financial advantages via a more operationally focused deployment of existing services.

All the figures in these analyses represent immediate benefits to our healthcare delivery system. However, they also highlight something more important and extensive: the greater level of control health systems have over day-to-day operations when they use data more effectively. That control allows clinical and operational improvements to be realized, refined and deployed more broadly.

Managing Value

The combination of a health system's clinical and administrative teams with an analytics team brings a business mindset to healthcare. The approach unites internal and external expertise in clinical, operational and analytical processes to objectively evaluate program performance in an evolving healthcare landscape.

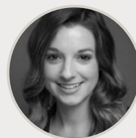
Giving hospitals and health systems greater visibility into operational outcomes provides a solid foundation for effective population health models. Early findings show VBC meets the needs of consumers while still maximizing provider reimbursements through high-quality care outcomes. In short, when applied effectively, VBC can drive better processes for care delivery to benefit all stakeholders — payers, providers and, most importantly, patients.

Contact a specialist at Mastercard to learn more about how Mastercard's patented predictive analytics solution Test & Learn® can help maximize program returns by getting the most value out of value-based care programs and initiatives.

Fope Agbedia
Principal, Business Development,
Mastercard
Fope.Agbedia@mastercard.com

Brandon J. Burket, MHA
Assistant Vice President,
Value Based Care & Population Health,
Orlando Health

Chris Roy
Managing Consultant,
Mastercard
Chris.Roy@mastercard.com



Claire Goodwin, MHA
Corporate Director,
Network Strategy & Business
Development, Orlando Health

About Mastercard

Mastercard is a technology company in the global payments industry. Our global network connects consumers, financial institutions, merchants, governments and businesses in more than 210 countries and territories. Mastercard Healthcare Solutions brings value to payers, providers and patients by working to enhance and grow business for payers and providers. Learn more at mastercard.com.

About Orlando Health

Orlando Health, headquartered in Orlando, Florida, is a not-for-profit healthcare organization with $7.6 billion of assets under management that serves the southeastern United States.

Founded more than 100 years ago, the healthcare system is recognized around the world for its pediatric and adult Level One Trauma program as well as the only state-accredited Level Two Adult Trauma Center in the St. Petersburg region. It is the home of the nation's largest neonatal intensive care unit under one roof, the only system in the southeast to offer open fetal surgery to repair the most severe forms of spina bifida, the site of an Olympic athlete training facility and operator of one of the largest and highest performing clinically integrated networks in the region. Orlando Health is a statutory teaching system that pioneers life-changing medical research. The 3,200-bed system includes 15 wholly-owned hospitals and emergency departments; rehabilitation services, cancer and heart institutes, imaging and laboratory services, wound care centers, physician offices for adults and pediatrics, skilled nursing facilities, an in-patient behavioral health facility, home healthcare services in partnership with LHC Group, and urgent care centers in partnership with CareSpot Urgent Care. Nearly 4,200 physicians, representing more than 80 medical specialties and subspecialties have privileges across the Orlando Health system, which employs nearly 22,000 team members. In FY20, Orlando Health served nearly 150,000 inpatients and nearly 3.1 million outpatients. During that same time period, Orlando Health provided approximately $760 million in total value to the communities it serves in the form of charity care, community benefit programs and services, community building activities and more. Additional information can be found at orlandohealth.com, or follow us on LinkedIn, Facebook, Instagram and Twitter @orlandohealth.

©2020 Mastercard. Mastercard is a registered trademark, and the circles design is a trademark, of Mastercard International Incorporated.